# DENTAL PLAN

## Summary of Dental Benefits

***Benefits by Design*** offers two dental plans—Plan A and Plan B—to help you pay for routine dental costs that result from preventive, therapeutic, and medically necessary restorative treatment. The dental plan does not cover orthodontic services.

Employees who choose dental coverage will be covered under the plan selected for **two plan years if they continue to be eligible for coverage**. Similarly, employees who waive dental coverage generally may not enroll for coverage for two plan years. (The plan year is the same as the calendar year, from January 1 through December 31.)

**Plan Features.** Both dental plans cover the same dental expenses. However, Plan B provides a higher level of coverage than Plan A for most services.

Dental coverage is provided by the Delta Dental Plan, using a program that includes contracted member providers. Although employees may go to any dentist, it is to their advantage to choose a Delta member dentist to minimize their out-of-pocket expenses.

If you obtain your dental services from a Delta dentist, you will only have to pay the amount of your deductible and copayment for covered services. Delta dentists will submit your dental claims for you and are not allowed to bill you additional amounts for charges that exceed negotiated rates. There are approximately 540 participating Delta dentists in Idaho and over 113,000 nationally. You may obtain a list of the participating Delta dentists in your area by contacting Delta Dental at 1-800-427-3237. Additionally, you may access this information through the direct link from the Benefits Homepage to the Delta Dental website.

The features of the two dental options are detailed below:

| Plan Features | Plan A | Plan B |
|---|---|---|
| Annual Deductible | | |
| Per person | $50 | $25 |
| Per family | $150 | $75 |
| Plan Pays:* | | |
| Preventive services (no deductible required) | 100% | 100% |
| Diagnostic services | 50% | 100% |
| Minor restorative services | 50% | 80% |
| Major restorative services and prosthodontic services | 50% | 50% |
| Maximum benefit per person per year | $750 | $1,500 |

*Subject to plan definitions and limits.

**Dental Plan Costs.** Your contributions for dental coverage are withheld from your paycheck on a pre-tax basis. The cost depends on the plan you choose and the coverage classification you select (employee only, employee and family, employee and children, or employee and spouse). You are not required to choose the same classification of dental coverage as you choose for medical coverage.

The company provides credits to offset against the cost of the dental plan you choose. Alternatively, if you don't wish to participate, you may opt out of the dental plan and receive a cash credit of $5 as an addition to your monthly pay (subject to normal income tax withholding), provided you are not covered under the dental plan as a dependent of your spouse.

## Covered Expenses

The following services are covered under the dental plans. Please note that if the charge is for a service or supply that has an appropriate alternative under accepted standards of dental practice, only the usual, customary, and reasonable (UCR) charge for the less costly procedure, service, or supply will be considered a covered dental expense. If a procedure, supply, or service is provided by a nonparticipating dentist, payment is based on the lesser of the actual charge or the UCR allowance.

**Preventive Services.** Preventive services and supplies are covered at **100%** of UCR charges with **no deductible**. These services include:

- Oral examinations – twice each calendar year
- Routine prophylaxis – teeth cleaning twice each calendar year
- Fluoride treatment by a dentist or dental hygienist to apply stannous fluoride twice each calendar year for covered children age 19 and under
- Space maintainers (initial appliance), including installation, fitting, and adjustments within 6 months of installation for covered children under age 16
- Emergency dental procedures performed to temporarily alleviate or relieve acute pain, discomfort, or distress, but which do not necessarily effect a definite cure
- Panoramic film, once every 3 years
- Bitewing x-rays twice each calendar year and full-mouth x-rays once every 3 years
- Dental sealants applied to the first and second permanent molars (without decay, without restorations, and with the occlusal surface intact), for eligible persons under age 25 when the teeth have not been treated with sealants for at least 4 years.

**Diagnostic Services.** Diagnostic services are covered at **50%** or **100%** of UCR (depending on the plan and provider that you choose) after you have paid the annual dental plan deductible. These services include:

- Dental exams and specialist consultations performed in connection with the diagnosis of a specific condition requiring treatment
- Dental x-rays requested in connection with the diagnosis of a specific condition requiring treatment
- Tests and laboratory examinations, including pulp vitality tests, biopsy tissue examinations, and study model diagnostic casts.

**Oral Surgery, Minor Restorative Services and Supplies.** Minor restorative services and supplies are covered at **50%** or **80%** of UCR (depending on the dental plan and provider that you choose) after you have paid the annual dental plan deductible. These services include:

- Periodontics–treatment of periodontal diseases of the gums and tissues of the mouth, including gingivectomy, gingival curettage, and osseous surgery (including post-surgical visits), pedicle soft tissue grafts, occlusal adjustments, and occlusal guards related to periodontal surgery.

  Also includes periodontal examinations and cleanings in accordance with Delta Dental guidelines. Both regular cleanings and periodontal cleanings, or any combination thereof, are limited to two in a calendar year.
- Endodontic procedures (procedures such as a root canal, used for treatment of dental pulp).
- Application of desensitizing medicaments.
- General anesthetics and their administration, including intravenous sedation, when performed in conjunction with cutting procedures in the oral cavity or when other desensitizing medications are not effective.
- Antibiotic drug injection by the attending dentist.
- Visits and professional consultation by someone other than the treating dentist.
- Amalgam, synthetic porcelain, and plastic filling restorations to restore diseased or accidentally broken teeth. Only the material used in accordance with accepted dental practices (not cosmetic) having the lesser charge will be covered.
- Repair or recementing of crowns, inlays, onlays, fixed or removable dentures; or relining or rebasing dentures more than 6 months after installation of an initial or replacement denture, but not more than one relining or rebasing in any 24-month period.

- Oral surgery, including necessary pre-operative treatment during medically necessary hospital confinement and customary post-operative treatment furnished in connection with oral surgery, such as:

  – Extractions

  – Alveolectomy, alveoplasty, stomato-plasty, and frenulectomy; excision of pericoronal gingiva, exostosis, hyperplastic tissue, and oral tissue for biopsy and tooth replantation

  – Any other oral surgery involving any tooth structure, alveolar process, or gingival tissue, except removal of a tumor or cyst or incision and drainage of an abscess or cyst.

**Major Restorative and Prosthodontic Services.** Major restorative and prosthodontic services are covered at 50% of UCR (subject to a review of medical necessity by Delta Dental) after you have paid the annual dental plan deductible. These services include:

- The restoration of missing teeth by artificial means, such as bridgework and dentures, including initial installation if teeth are extracted while covered under this plan. Replacement of bridgework and dentures are covered if installed at least five years prior to the replacement and if they cannot be repaired (as determined by Delta Dental). Check with Delta Dental for full details on this coverage.

- Inlays, onlays, gold fillings, or crown restorations (including stainless steel) to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries and fractures, cannot be restored with an amalgam, synthetic porcelain, or plastic filling restoration. When a tooth can be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration, benefits will be determined based on such a restoration.

- Replacement of an existing inlay, onlay, gold filling, or crown restoration as described above. However, if such appliance is installed while you are covered under this plan, at least 5 years must have elapsed before it may be replaced. The only exception is if replacement is required as a result of accidental bodily injury sustained while covered under this plan.

- Implants or their removal are not covered under this plan. However, if implants are provided in association with a covered prosthodonic appliance, Delta will allow the cost of a standard complete or partial denture toward the cost of the implant procedures and prosthodontic appliances. In this event, Delta will not pay for any replacement placed within five years thereafter.

# Predetermination of Dental Benefits

If your dental treatment involves services costing $100 or more, or if you will be receiving major restorative or prosthodontic services (as described earlier), it is advisable to ask your dentist to submit a predetermination of benefits.

A statement will be sent to your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. Please note that claims for other completed dental services received and processed prior to the completion date of the proposed treatment may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predetermination estimates are valid for 90 days from the date issued by Delta Dental, subject to your continued eligibility in the Plan and the continuation of Delta Dental's contract with BBWI.

# Dental Services Not Covered

Services **not** covered under the plans include, but are not limited to, the following:

- Procedures, services, or supplies primarily for cosmetic purposes, including charges for personalization or characterization of dentures and precision attachments.
- Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.
- Replacement of a lost, missing, or stolen duplicate prosthetic device or other dental appliance.
- Implantology, including implants and appliances constructed in association with implants, and the surgical removal of implants (except as noted above under Major Restorative Services); and for other procedures, services, or supplies which are experimental.
- Appliances or restorations considered by Delta Dental to be necessary to alter, restore, or maintain occlusion, or to increase vertical dimension, including, but not limited to, treatment and diagnosis of temporomandibular joint (TMJ) syndrome, splinting, and replacing tooth structure lost as the result of abrasion or attrition.
- Charges for periodontal splinting of teeth, except for provisional, intracoronal stabilization of mobile teeth.
- Drugs and/or medications, (including prescriptions, applied therapeutic drugs, premedications, and analgesia), other than injection of antibiotics.
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.

- Hospital charges and any additional fees charged by the Dentist for hospital treatment, unless determined to be medically necessary by Delta Dental.

- Services for injuries or conditions which are compensable under Worker's Compensation.

- Services for which you or your dependent(s) are not required to pay and services provided by any Federal or State Government Agency.

- Charges incurred after coverage ends, except as noted elsewhere in this handbook.

- Procedures, services or supplies started before you or your dependents became covered under the plan.

- Procedures, services or supplies furnished by someone other than a licensed, legally qualified dentist, acting within the scope of his or her license. The only exception is for charges performed by a licensed dental hygienist acting within the scope of his or her license and under the supervision and direction of a legally qualified dentist.

- Replacement of existing restorations for any purpose other than restoring active tooth decay.

- Facings on pontics or crowns posterior to the second bicuspid.

- Procedures, services, or supplies that are not necessary according to acceptable standards of dental practice, or do not meet acceptable standards of dental practice, including charges for procedures, services, or supplies that are experimental.

- Procedures, services, or supplies furnished because of an injury, disease or dental defect resulting from war or any act of war, declared or undeclared.

- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis, and anodontia.

- Diagnosis or treatment by any method of any condition related to TMJ syndrome.

- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

- Precision attachments, except when they are the sole method of completing a course of treatment.

- Orthodontic services.

# Using Your Dental Program

**Filing Claims.** Under the Delta Dental Program you are free to go to the dentist of your choice. If your dentist is a participating dentist, the claim form will be available at the dentist's office. The dental office will file the claim form with Delta Dental; however, you may be required to assist in completing the patient information portion of the form.

If you go to a nonparticipating dentist, you may obtain a claim form from the Benefits Office, the company reception desks in Idaho Falls, or the various medical dispensaries. Delta Dental also accepts the standard ADA claim form used by most dentists. Claims must generally be submitted to Delta within six months of the date of service.

During your first dental appointment, it is very important to advise your dentist of the following information:

- Your Delta Group Number (5440)
- Your employer's name (BBWI)
- Your Social Security number (your dependents must use YOUR Social Security number)
- Your birthday and those of your eligible covered dependents.

**Please answer all questions on the claim form. If you do not answer all questions, your claim processing will be delayed.**

Questions regarding your dental claim payment or coverage should be addressed directly with your Delta dentist. If you use a nonparticipating dentist and have questions regarding your claim or coverage, please call Delta Dental at **1-800-548-5468.**

Please note that charges for services of non-participating dentists will not be eligible for processing unless your claim is filed within 12 months of the date such services are provided.

**Claim Review.** The Dental Consultant of Delta Dental and/or any other dentist whom Delta Dental may designate shall have the right to resolve any question concerning coverage of dental services (or the necessity or choice of treatment) which may arise hereunder. Any such determination made in good faith shall be conclusive and binding upon Delta Dental, the patient and the dentist, unless within 90 days following receipt of written notice of the rejected procedure or other written notice of such decision, any person aggrieved thereby shall appeal the same to Delta Dental for determination by a second dentist. When appealing a denial of benefits, please include the group name (BBWI) group number (5440), name, employee's social security number and a phone number, in addition to a copy of the treatment form, notice of payment, and any other relevant information. Such second determination shall be final and binding on all parties and not subject to any further appeal, arbitration or judicial review.

Any controversy or claim arising out of or relating to this contract or the breach thereof, other than a question concerning coverage of dental services or the necessity or choice of treatment which is to be determined under the provisions above, shall be settled by arbitration in accordance with the arbitration statutes of the State of Idaho in effect at that time, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The rules of the American Arbitration Association shall be followed in such arbitration proceeding.

**Keeping Records.** It is necessary to keep separate records of your expenses for each of your dependents and for yourself because the plans operate separately for each covered family member. You should become familiar with the information needed to file a dental claim in order to keep records that will save you time and effort when you submit claim forms.

## How Your Dental Benefits Are Coordinated

If you or your dependents are entitled to any dental benefits from any other group plan, the ***Benefits by Design*** plan will coordinate benefit payments with payments from the other plans so your **total benefit** from all plans will not be more than 100% of the medically necessary R&C charges. This may mean a reduction in benefits under this plan. The company will not coordinate benefits with any individual insurance you purchase on your own.

In a calendar year, this Plan will pay:

- Its regular benefits in full, or
- A reduced amount of benefits. To figure this amount, subtract (B) from (A) below:

  (A) 100% of "Allowable Expenses: incurred by the person for whom claim is made.

  (B) The benefits payable by the "other plans." (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

Plans that coordinate benefits with the dental plan are:

- Group, blanket, or franchise coverage (except student accident insurance)
- Group prepayment plans, including Health Maintenance Organizations (HMOs)
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans

- Any coverage under governmental programs, and coverage required or provided by law, except for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, or Medicaid

- Other insured or self-insured group coverage.

You must provide information about any additional dental coverage you or your covered dependents have on your claim form. If you do not report other group insurance coverage, claim processing could be delayed.

**Which Plan Pays First.** To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

- A plan which covers a person other than as a dependent (for example, as an employee) will be deemed to pay its benefits before a plan which covers the person as a dependent. An exception to this rule is made when the person is also covered by Medicare, and Medicare is both (1) secondary to the plan covering the person as a dependent, and (2) primary to the plan covering the person as other than a dependent. In this situation, the benefits of the plan which covers the person as a dependent will be determined first.

- A plan covering the person as an employee (who is neither laid off nor retired), or as that employee's dependent, pays before a plan covering a person who is laid off or retired (or that employee's dependent). However, if the other plan does not have this rule and the order of benefit payment does not agree between the two plans, this rule does not apply.

- A plan covering the person under a right of continuation pursuant to federal or state law pays after any other plan which covers the person other than such right of continuation. However, if the other plan does not have this rule, and the order of benefit payment does not agree between the two plans, this rule does not apply.

- Except in the case of a dependent child whose parents are divorced or separated, if a child is covered under both parents' plans:

  – The plan of the parent whose birthday falls earlier in a year pays first

  – If both parents have the same birthday, the plan covering the parent longer pays first

  – If the other plan does not use the "birthday rule" described above, but instead has a rule based on the gender of the parent, the rules of the other plan will determine the payment order of benefits if different from the order described under this plan.

- In the case of a dependent child whose parents are divorced or separated:

  – If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the dental care expenses of the child, the "birthday rule" provisions described above will apply.

  – If there is a court decree which makes one parent financially responsible for the dental care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

  – If there is not a court decree and two or more plans cover a child, the plan of the parent with custody of the child pays first (if the parent has not remarried).

    If there is not a court decree and the custodial parent has remarried, that parent's plan will pay benefits first, the stepparent's plan second, and the plan of the parent without custody pays third.

- If none of the above provisions determine the order of benefit payments, the benefits of the plan covering a person longer are determined first.

Delta Dental has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

**Subrogation.** In some cases, this plan may pay expenses for an injury or illness that was caused by another person who could be legally responsible for those expenses. If that happens, this plan has the right to be repaid or reimbursed from any amounts you may recover from that person or organization.

You will be required to authorize an assignment or other legal document on behalf of the plan to protect the plan's rights to recover any amounts that have been paid to you or on your behalf.

## When Your Coverage Ends

**Employee.** Your dental coverage will end (except as permitted under COBRA) on the **earliest** of the following:

- The last day of the month in which your full-time employment ends.

- The last day of the month in which you retire.

- The last day of the month in which you are no longer eligible.
- The first day of the month in which you no longer make any required contributions for coverage.
- The day on which the plan ends.

You may continue coverage while you are on unpaid leave of absence (including time off without pay, family medical leave, inactive employee status, and military leave for active duty) only if you continue to pay your monthly cost for the coverage.

**Dependents.** Dental coverage for your dependent(s) ends (except as permitted under COBRA) on the earliest of the following:

- The day your coverage ends.
- The last day of the month in which your dependent is no longer eligible for coverage.
- The first day of the month in which you no longer make contributions for dependent coverage.
- The last day of the month for which the last required payment is made by the participant (as in COBRA).
- The day on which the plan ends.

## Coverage Continuation Provisions

**Survivor Dental Benefits.** If you die while covered under the dental plan, coverage for your covered dependents will continue until the earliest of the following:

- Three months after the end of the month in which you die
- The last day of the month in which your dependent(s) is no longer eligible for coverage
- The last day of the month in which your dependent(s) becomes eligible for Medicare Part A
- The first day of the month in which your dependent(s) no longer makes contributions for coverage
- The day on which the plan ends.

Your dependents may be eligible to elect continued coverage under COBRA.

**Your Benefits at Retirement.** Once you retire, neither you nor your dependent(s) may continue in the ***Benefits by Design*** dental plan, except as provided under COBRA.

**Conversion Privilege.** You may not convert your dental coverage to an individual Delta Dental plan.

# Continued Coverage (COBRA)

If you or your dependent(s) become ineligible for coverage under the ***Benefits by Design*** dental plan, continued coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) may be available if you (or your dependents) enroll and pay the applicable costs. Except in cases where coverage is extended due to disability, your cost for this coverage is 102% of the full cost of coverage.

**Eligibility for Continued Coverage.** To be eligible for continued coverage (COBRA), you or your dependent(s) must be covered under the ***Benefits by Design*** dental plan immediately before you request continued coverage. You may elect to continue the same dental plan you enjoy as an active employee. (However, you will not pay the same contribution you paid as an active employee.)

You and your covered dependent(s) may continue coverage through COBRA when regular coverage ends due to one of the following events:

- Your full-time employment ends
- Your employment status changes from regular full-time to temporary or part-time.

Continued coverage is also available to your covered dependents when their regular coverage ends due to one of the following events:

- You die
- You become divorced or legally separated
- Your dependent ceases to be eligible for coverage
- You become eligible for or entitled to Medicare Part A benefits.

**Duration of Continued Coverage.** Continued coverage for you and your eligible dependents may extend for up to **18 months** after you end full-time employment or your employment status changes.

Continued coverage for your dependents may extend for up to **36 months** after your death, divorce, legal separation, or eligibility for Medicare. Additionally, your dependents may continue their coverage for 36 months if they become ineligible for coverage.

Coverage may end sooner than the times specified above if one of the following events occurs:

- The cost for a covered individual is not paid within 30 days following the first of the month for which the payment is due. (For example, if the payment for January is not paid by January 31.)

- The covered person becomes eligible, while on COBRA, for Medicare benefits or becomes covered under another group health plan (unless the plan does not cover a pre-existing condition of the covered person)

- The ***Benefits by Design*** plan ends.

**If You Are Disabled.** Generally, if you or a covered dependent is disabled, the disabled person will be eligible for continued coverage for up to 18 months, whether or not he or she meets the Social Security Administration's definition of "disabled."

Continued coverage may be extended **after** 18 months if you or your dependent is disabled as defined by Social Security either on the date your employment ended (or within 60 days thereafter) or, alternatively, on the effective date of an employment status change that makes you and your dependents eligible for continued coverage.

Under these circumstances, the disabled person will be eligible to continue coverage for up to 11 additional months (up to 29 months **total**). Non-disabled dependents (of the disabled person) who are entitled to COBRA coverage are also eligible for the 11-month extension of coverage. To elect an extension of dental coverage for a person who is determined to be disabled under Social Security, you must notify the Benefits Office by the earlier of (1) 60 days after the person is declared disabled, or (2) the last day of the initial 18-month coverage continuation period. The cost of coverage for the additional 11 months will be 150%, rather than 102%, of the full cost of coverage.

Continued coverage for disability may end sooner than 29 months if you or your dependent is no longer considered disabled by Social Security. Coverage for non-disabled dependents would end if your own coverage were to terminate before the end of 29 months.

**Election Period/Notification.** You have a certain period of time in which to elect continued coverage, as described below. If you do not elect continued coverage during this period, or if you give up your right to continued coverage, your decision is considered final. **You will not have another opportunity to elect continued coverage.**

The company will notify you, or your dependent(s) if applicable, of the right to continue coverage under COBRA as soon as the company is aware that regular coverage will end because you end active employment, retire, become eligible for Medicare benefits, change your employment status, or die. You or your dependent(s) have 60 days from that notification or the date of the event (whichever is **later**) to elect continued coverage.

You or your covered dependent(s) must notify the Benefits Office within 60 days if eligibility ends due to divorce or your dependent child losing eligibility. The company will then notify you or your dependent(s) of the right to continue coverage. You or your dependents have 60 days from notification by the company to elect continued coverage.

**Paying for Continued Coverage.** If you or your dependents elect continued coverage, the cost of at least the first month of coverage must be paid within 45 days after you elect continued coverage. You will be charged from the date you become eligible for continued coverage, regardless of when you elected the coverage during the election period. To ensure timely reporting of eligibility and avoid delay in processing your claims, you should remit the contribution amount before the first of the month for which the payment is being made. Your coverage will be terminated without notice if the Benefits Office does not receive your payment within 30 days after the first of the month for which the payment is due.

**Payment of Claims.** If you or your dependent(s) elect to continue coverage when it is first offered, claims will be payable from the effective date of coverage. However, claims cannot be processed unless you have paid the cost of coverage.

If you or your eligible dependents **do not** elect to continue coverage (COBRA), the ***Benefits by Design*** plan will not pay benefits for expenses you or your dependents have after the date your coverage ends. This applies **even if** the condition being treated began while you or your dependents were covered by the plan.

# Definitions

**Company** means Bechtel BWXT Idaho, LLC.

**Disabled (totally)** means you are not able to perform any of the usual and customary duties of any occupation. For dependents, this means your dependent cannot perform any of the usual and customary duties or activities of a person in good health and of the same age.

**Employee** means a regular full-time employee of the company, excluding in all cases, part-time and temporary employees.

**Medically necessary** services include any confinement, treatment, service or supply that is prescribed by a dentist legally licensed to practice medicine and surgery and considered by Delta Dental or an independent review panel to be:

- Necessary, appropriate, and consistent with the diagnosis according to national acceptable standards of practice
- Nonexperimental or noninvestigational.

**Usual, Customary, and Reasonable (UCR)** fees are defined as follows:

- For Delta Dentists, the UCR fee for any single procedure is the fee which the Dentist has filed with Delta and which Delta has accepted as follows:

  – A usual fee is the amount which a Dentist regularly charges and receives for a given service. If a Dentist charges more than one fee for a given service, the "usual" fee for that service is the lowest fee which the Dentist regularly charges or offers to patients.

  – A fee is customary when it is within the range of usual fees charged and received for a particular service by Dentists of similar training in the same geographic area which Delta determines is statistically relevant.

  – A fee is reasonable if it is "usual" and "customary," or if Delta agrees that a fee that falls above customary is justified by a superior level of care or by the extraordinary circumstances of the case in question.

- For a non-participating Dentist, his or her "usual, customary, and reasonable" fee is presumed to be the "prevailing fee" for that procedure. The "prevailing fee" is the fee for a single procedure which satisfies the majority of Dentists in Idaho, as determined by Delta based upon confidential fee listings accepted by Delta from participating Dentists.